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## ORIGINAL ARTICLES

### URETERAL STRICTURE.*

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In discussing this subject of Ureteral Stricture, the intention is to study those strictures due to an inflammatory process within the ureteral wall itself. Ureteral strictures due to intrinsic inflammatory changes within the ureteral wall are far more common than we are prone to believe. In fact, it is only within recent years that these conditions have been given thorough recognition and study. Hunner deserves the credit for having studied and reported a great many of these cases and has been instrumental in having presented a satisfactory treatment for this class of sufferers.

ETIOLOGY.

Not until recent years has the cause of this condition been worked out. For a long time every stricture of the ureter was thought to be due to a congenital malformation.

Kelly anticipated our more modern knowledge of the subject in 1902 by stating "strictures are caused by an inflammation in the ureteral walls produced by the more common pyogenic cocci, by the gonococcus, and by the tubercle bacillus, and the rarest in my experience in women is due to the gonococcus." On the contrary, Garceau, in 1903, after reviewing the literature and judging from his own experience, says: "The chief cause of fibrous stricture is gonorrheal infection." Furniss believed that most ureteral strictures were congenital in origin, but later concluded that infection played the important part in their etiology. He says: "The infiltration in the ureter is the result of an acute hematogenous infection of the kidney which often persists as a pyelitis, urethritis or secondary cystitis." Kelly and Burnham, in speaking of traumatic stricture, say: "Traumatic stricture of the vesical end of the ureter following the injuries of labor and surgical operations, especially the Wertheim operation for cancer of the cervix uteri, is quite common. As a rule, the trauma has so interfered with the blood supply of the ureter that there is lateral necrosis, causing a continuous leakage of the urine, and a resultant urethrovaginal fistula. The spontaneous healing of such a fistula almost invariably means stricture."

Gunshot wounds and stab wounds are rare etiological factors, but Morris reported five cases in 1901.

Trauma, such as would crush the pelvic bone or rupture the pelvis of the kidney or bladder, may leave an injury so sufficient that in later years it may cause a stricture.

As to sex, ureteral stricture is far more common in females, probably due to the easier avenue of infection through the external genitalia.

I admit the possible and probable factors mentioned above as causing some of the strictures, although I am firmly convinced that the majority of ureteral strictures, not including those of tuberculous origin, should be classed as a simple chronic inflammatory process which has its origin in an infection carried to a site in the ureter from distant foci such as diseased tonsils, sinuses, teeth, and so forth.

SYMPTOMS.

A patient suffering from a stricture of the ureter usually complains of a long standing pain, the cause of which could not be ascertained. The pain chart of this condition would be hard to make perfect, as their pain may be in the kidney region, inguinal region, over the appendix, in the epigastrium,

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around the umbilicus, in the bladder, in the urethra, or it may radiate to the sacrum or down the lower extremities. There is often frequent urination and not infrequently a history of hematuria. Very seldom does the patient call attention to any localized symptoms produced by the stricture. From the point of inflammation, pain may radiate in any direction; laterally into the hips or groin region, or posteriorly simulating a sacro-iliac joint or a sciatica, or downwards into the thigh and leg. There may be pains in the lumbar region due to overdistention of the kidney pelvis. Frequently there is a history of indefinite pains in the lower abdomen. Any of these pains may be induced by an auto ride, overexercise, going up steps, getting the feet wet, menstruation, or unusual exposure.

*Temperature:* Chills and fever are common in cases where there is infection. I have had cases of pyelitis where there was no chill and no appreciable fever, and the only symptoms were general malaise and mental depression. In such cases, should the stricture close and cut off free drainage, there is usually a chill and high temperature. It is important to know that a patient may run a high temperature without demonstrable infection of the kidney pelvis or bladder.

*Gastrointestinal Tract:* These symptoms may be from the central nervous system, reflex, or a result of absorption of toxins. These are the same as those symptoms produced by a stone in the ureter, or any other cause of obstruction to the flow of the urine through the ureter. The symptoms vary from slight nausea with loss of appetite to extreme nausea and vomiting lasting over a period of a couple of weeks. Often the patient will complain of gas distention with indigestion and eructation. Occasionally there is complaint of rectal tenesmus and a desire for stool. Pain just before or during stool in some cases is likely due to fecal matter passing over the tender peritoneum near the site of the ureteral stricture.

*Mental Symptoms:* These are similar to those found in any general toxic condition. Headaches are not infrequently complained of.

MORBID ANATOMY.

Hunner has reported the macroscopic appearance of about fifteen cases operated upon. The inflammatory area varies from a slight annular thickening in the ureteral wall to a condition of diffuse cartilaginous thickening which may occupy several centimeters of the ureter. Multiple annular strictures are not uncommon. The infiltration may be confined to the ureteral wall or there may be extensive periurethritis.

Microscopically, the stricture area shows a chronic inflammation. The epithelium is changed from the transitional stratified to a more squamous type. The epithelium may be denuded, resulting in an ulcer in the stricture area.

LOCATION OF STRICTURES.

In a great majority of cases the stricture is in the broad ligament region or within 5 or 6 cm. of the bladder. The next most frequent location is at the bifurcation of the internal iliac vessels, or about 8 to 10 cm. above the bladder. In both of these regions there are a great many lymphatic glands, and at operation these glands have been found enlarged. In a series of twenty-four cases I found seven strictures were bilateral, eighteen were unilateral, eleven were on the right side and seven were on the left.

RELATION OF STRICTURES TO OTHER PATHOLOGICAL CONDITIONS OF THE URINARY TRACT.

*Changes of the Upper Urinary Tract Due to Stricture:* The kidney pelvis may vary in capacity from normal to one holding 200 c. c. or more. Cases of hydronephrosis naturally greatly impair the function of the kidney.

*Bearing of Ureteral Stricture on Stone Formation:* As it is true that kidney and ureteral stones are the result of the deposits of salts, it makes the study of ureteral stricture more interesting. A stone may begin to form at the site of an inflammatory por-

tion of the ureter, or it may originate in the pelvis of the kidney and be passed down to the strictured portion of the ureter, where it may become lodged and receive a continual deposit of urinary salts.

The consensus of opinion is that there must be a nucleus for deposits, such as epithelial cells, bacteria, or blood cells, before a stone can be formed. If this be true, we must admit that the small particle must have a resting place before a stone can form, for this formation may take months or years to develop. Therefore, if the ureter is open and there is free drainage from the pelvis, such a small particle will have a clear passage into the bladder. Should there be an obstruction in the ureter resulting in a hydronephrosis, this dilated pelvis would afford an ideal location for stone formation. A small stone passing down the ureter may be lodged in any constriction of the ureteral lumen and there easily enlarge by means of more deposits.

*Influence of Ureteral Stricture in Pyelitis:* In dealing with any localized pyogenic infection it seems needless to state that the better the drainage the more quickly will good results be obtained. The same principle holds true in pyelitis with a stricture and resultant poor drainage. The stricture should be dilated first and then pelvic lavage instituted while the catheter is in place.

DIAGNOSIS.

The diagnosis of ureteral stricture depends upon the history, palpation of the abdomen, palpation of the ureters through the vagina or the rectum, cystoscopy, catheterization of the ureters by the wax bulb catheter and roentgenography.

Symptoms should be studied carefully. Remember that experience has taught us to suspect stricture in any patient complaining of obscure abdominal pain which, in some cases, is referred pain into the urethra or down the thighs.

*Physical Examination:* On deep palpation over the ureteral regions, not infrequently there will be definite tenderness. Following attacks of pain, soreness and tenderness in the ureteral areas are not uncommon. Often there is tenderness on pressure in the kidney region. In some cases a very tender kidney is due to the excess back pressure of urine in the pelvis due to the stricture. On vaginal palpation, where the stricture is in the broad ligament region, there may be definite tenderness at that point.

*Urinalysis:* Long-standing ureteral stricture cases will usually present negative findings. Even cultures from the bladder or kidney show no growth. However, occasionally, microscopic examination does show a few red cells and leucocytes.

*Cystoscopy:* Frequently careful examination is quite negative. In cases where a stricture is near the ureteral orifice, the latter may present an edematous puckering or redness, which is quite suggestive. Many cases of ureteral stricture will show a stricture of the urethra, evidencing an old urethritis.

*Catheter Test:* The wax bulb catheter is the positive test in the diagnosis. I use a No. 6 renal catheter, and make a corkscrew tip of wax, and also adhere a wax bulb of 4 m. m. diameter about 8 cm. from the tip of the catheter. The waxed tip of the catheter readily passes through a stricture, and on removal of the catheter, the wax should be carefully examined for scratch marks due to a stone in either the ureter or the kidney pelvis. The wax bulb referred to serves a double purpose. It will show scratch marks from a stone should one be present in the ureter. Its more important function is that on withdrawal of the catheter, the bulb will hang in the stricture area, and forced passage of the bulb through the stricture usually produces the patient's old pain.

It is important to know that a renal catheter of large size may be passed without detecting a stricture. If a hydronephrosis is found, suspect a ureteral stricture. A chill followed by temperature following ureteral catheterization of a pyelitis case is suggestive of a stricture.

In passing a bulb catheter, diagnosis of a ureteral stricture should not be based upon an obstruction felt in introducing the catheter, but upon the hang of the bulb as the catheter is withdrawn. Occasionally a grating sensation is detected as the bulb is withdrawn through the strictured area due to the presence of scar tissue.

*Roentgenography*: Seldom is the aid of a roetgen-ray examination necessary in determining the presence of a stricture. Occasionally, when there are symptoms leading one to suspect a stricture and yet no definite hang is experienced on withdrawal of the wax bulb catheter, roetgenography serves as a valuable aid, for a stricture pronounced enough to cause symptoms may be so lacking in scar tissue as to offer no obstruction to the passing of the bulb. In obtaining a roentgenogram, the wax bulb is passed into the ureter well beyond its orifice. A solution of sodium bromide or thorium is injected through the catheter, filling the ureter and kidney pelvis. Either of these solutions throws a shadow on the plate and clearly outlines the walls of the ureter and kidney pelvis, disclosing very readily a hydronephrosis or dilated ureter, if either is present. The plate is made while the catheter is in situ.

DIFFERENTIAL DIAGNOSIS.

Tuberculosis of the ureter would be likely to cause a stricture of its lumen. A tuberculous kidney would cause haematuria. It is advisable to use the guinea-pig test in all cases of ureteral stricture to rule out a Koch infection.

Syphilis should be excluded by the routine Wassermann test.

Other conditions to be borne in mind are cystitis, pyelitis, pyonephrosis, floating kidney, hydronephrosis, chronic nephritis, inflammatory disease of the pelvic organs, various functional disorders of the stomach and intestines, intestinal adhesions, colitis, gall-stones, appendicitis, lumbo-sacral or ilio-sacral joint pains, and sciatica.

TREATMENT.

The immediate object desired is dilatation of the stricture with relief of symptoms. To prevent recurrence, any infection of the urinary tract, or focus of infection elsewhere, must be removed.

If a thorough dilatation of the ureteral stricture is accomplished, I believe a permanent cure may be expected. The ideal treatment for stricture of the ureter is by dilatation from the vesical approach. When the stricture is in the ureteral orifice, there may be difficulty in introducing the catheter. In several cases I have had to use filiforms and a metal searcher to open the ureteral orifice before the catheter would engage. Occasionally when the olive-tip catheter failed, I have successfully used the whistle-tip.

If the patient has bilateral strictures, each should be treated on a separate day. I have found it best to give treatments about every ten days, as in that time the traumatic edema has had time to subside.

Dilatation of the stricture is accomplished by use of the wax bulb catheter described above. It is advisable to make the bulb of wax 3 2-3 m. m. in diameter for the first treatment. The catheter is passed into the ureter through the cystoscope, the bulb gently forced beyond the stricture and then withdrawn. The diameter is gradually increased for each treatment until a bulb of 5 1-3 m. m. in diameter is used. This can usually be accomplished by the third to fifth treatment, depending upon the density of the stricture.

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## PYURIA.*

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Pyuria, defined as pus in the urine, is often misleading. Pyuria is pus, of known urological origin found in urine. Pus found

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in urine is classified by the laboratory worker, according to the number of pus cells, into few, moderate, and many. These loosely applied terms are indications of the amount of pus in a particular specimen, and should not be accepted as evidence of the degree of existing pathology.

Pus in the urine may occur in any pathological condition of the urinary tract, and is the predominating evidence of urethral and renal infections. Urethral infections, including prostatitis and seminal vesiculitis, are nearly always the result of gonococci, and is the most generally known of the causes of pyuria. Bladder infections, or the overworked "cystitis," is not a disease *per se*, but is usually a symptom of a number of pathological conditions.

Renal infections represent the least known causes of pyuria and, consequently, the most poorly treated. For a better and more comprehensive view of renal infections it is necessary to explain the principles governing these. Of the various bacteria found, the bacillus coli and pyogenic cocci predominate.

The routes of invasion of the kidneys are by the blood stream, the lymphatics, direct extension of adjacent inflammation into the kidneys, and by trauma. Of all these causes, infection by the blood stream is the most common. Modern methods of blood culture have shown the not uncommon occurrence of living bacteria in the circulating blood. However, it has been conclusively demonstrated that all bacteria can pass through the kidneys without permanent injury to this organ. So, in order that renal infection can occur, it is necessary that some condition, either mechanical or toxic, has reduced the resistance of one or both kidneys. This condition is known as an accessory cause and may be either urinary retention, trauma, or toxic influences. Renal infections are classified as:

1. Acute suppuration of the kidney,
   (a) Pyemic kidney,
   (b) Focal suppurative nephritis,
2. Acute pyelonephritis,
3. Chronic pyelonephritis,
4. Pyonephrosis,
5. Infected hydro-nephrosis,
6. Perinephritis.

The pyemic kidney is the result of a general pyemia, bilateral, and is of interest only as a post-mortem study. The renal infections, with this one exception, represent cases, as a rule, amenable to treatment. However, the result of treatment depends entirely upon the correctness of a diagnosis, and a correct diagnosis is impossible without scientific use of modern means of study.

Pyuria—frequent and painful urination—when found in a case has been the general alarm of the medical fire department, and water by the gallon has been poured into the bladder. The multicolored additions to our host of bladder washes are no doubt pleasing to the artistic eye of the medical man who delights in the effect of color, but his method is *passe*, and the earlier we realize this truth the better it will be for our patients.

Fifty cases have been selected from the section of urology of the Bayside Hospital for study. All of these cases presented pyuria as a predominating symptom. Every case so listed had not been diagnosed on entrance to the hospital, but came seeking relief for pus in the urine. No cases have been included of acute urethral infections, or where pyuria was not discovered before entrance into the hospital. Anatomical divisions have been made and diagnosis listed under respective heads:

| | |
|---|---|
| **KIDNEY:** | |
| Pyelonephritis (colon group) | 5 |
| Pyelonephritis (typhoid carrier) | 1 |
| Calculus | 3 |
| T. B. | 1—10 |
| **URETER:** | |
| Stricture | 9 |
| Calculus | 5—14 |
| **BLADDER:** | |
| Carcinoma | 3 |
| Diverticulum | 3 |
| Calculus | 3— 9 |
| **PROSTATE:** | |
| Contracted (median var.) | 1 |
| Adenoma | 4 |
| Carcinoma | 1 |
| Infectious (prostatitis and vesiculitis) | 4—10 |

| | | |
|---|---|---|
| URETHRA: | | |
| Stricture | 5— | 5 |
| GENERAL: | | |
| Caisson Disease | 1 | |
| Cerebrospinal syphilis | 1— | 2 |
| | | 50 |

The ages were from 19 to 81; females, 18; males, 32. The females distributed as follows: Pyelonephritis (colon group), 4; typhoid carrier, 1; kidney calculus, 2; ureteral stricture, 7; ureteral stone, 2; urethral stricture, 2.

Under the anatomical division of kidney the cases classified as pyelonephritis (colon group) represent the series which we were unable to definitely determine accessory causes.

The case of renal T. B. presented some very interesting features. A man 68 years of age, born in Germany, but a citizen of America since 9 years of age. Contracted pulmonary tuberculosis when 28 years of age. At that time had bladder irritation for six months. On moving to Nevada and living an outdoor life, his pulmonary and bladder symptoms disappeared. Has lived in Florida for nine years. Six months before entrance into the Bayside Hospital he was confined to his bed with a severe attack of influenza. Near the end of his influenza attack, noticed frequent and painful urination. The first attack subsided within three or four days; since then has had, periodically, similar attacks. Pus has been in the urine constantly since first attack. He sought relief for pus in the urine.

At the time of entrance into the hospital he was urinating four to six times daily and from one to two times at night. A sterile specimen of urine was obtained from the bladder and T. B. found. Cystoscopic examination demonstrated a marked inflammatory zone around left ureteric orifice. The left ureter was blocked one inch above the orifice. Specimen from the left ureter showed only pus. Guinea-pigs inoculated from both kidneys demonstrated T. B. from left. A diagnosis of closed left renal T. B. was made.

*Conclusions.*

First. That pyuria is a symptom.

Second. That the indiscriminate use of urinary antiseptics and bladder lavage is the height of folly.

Third. The necessity of a more complete scientific study of cases presenting pyuria as a symptom.

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## NEURO-SYPHILIS — SOME PRESENT-DAY OPINIONS CONCERNING.

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In a paper on "Neuro-Syphilis," we must constantly bear in mind that we are dealing with special phases of a general infection. Not only this, but we are dealing with an advanced stage of a serious disease, and in some of its varieties, as paresis and tabes, stages which until quite recently were not considered amenable to treatment.

When the psychiatrist or neurologist has before him a number of people showing the diagnostic features of any form of neuro-syphilis, he asks himself two questions: 1st. How many of these might have been cured or arrested before this stage was reached? 2nd. How much may still be done for them?

No one can, at the present time, give a satisfactory answer to either of these questions, but scientific research is working daily to answer both, and we should all have open minds for the consideration of its discoveries and solution of problems, at the same time requiring the acid test before becoming too enthusiastic over new remedies and methods of treatment.

Of that phase of syphilis, broadly termed neuro-syphilis, there are two types: 1st. That type which affects the arteries and meninges primarily, and the nerve cells and fibers secondarily. This is called meningo-vascular or exudative syphilis. 2nd. That type which causes degeneration of nerve cells and fibers by direct attack. This is parenchymatous or degenerative syphilis.

*Meningovascular Syphilis.* — This type comprises the conditions known as cerebral syphilis, spinal syphilis, cerebrospinal syphilis, syphilis of the peripheral nerves, etc., and, of course, the symptoms are determined largely by the areas involved. The cranial nerves are frequently affected, but the spinal nerves are not often involved. The arteries and meninges are affected by a round cell exudate which causes either some form of gumma or obliteration of the lumen of the blood vessels. In case of the gumma we, of course, have pressure symptoms of all kinds, while obliteration of the lumen of blood vessels gives a deficient blood supply and thus causes so-called brain softening.

*Parenchymatous Syphilis.*—This is what has been called parasyphilis, as it was thought to be produced in some obscure way, but as more is being learned of the cause and nature of this disease, such terms as para and metasyphilis are falling into disuse. The principal manifestations of this type are paresis and tabes dorsalis. Both, as stated above, were until quite recently considered incurable.

The time elapsing between the initial infection and the development of well-defined neurosyphilis varies by many years and are first indicated by quite different symptoms, as can be readily seen from a very brief sketch of a few well-marked cases.

Case No. 1.—A white man, in the navy, had chancre at age of twenty-two; was given considerable treatment. At age of twenty-nine began having headache, vertigo, loss of memory, speech defects and other diagnostic signs of paresis.

Case No. 2.—A white man, soldier, had chancre at age of twenty-one; suddenly lost his efficiency at thirty-six; in a few days he became hyperactive; was going to do this, had to do the other. Much depended on his immediate activities. Next day developed a severe headache, was confused and disturbed. Reflexes and speech defects appeared in a very short time, plainly indicating paresis, which diagnosis was borne out by typical serological findings.

Case No. 3.—A white man; occupation, naval stores operator; single; had chancre at age of seventeen; cured chancre with "calomel powders." At thirty-four enlisted in the army for service in world war. Carried on well for more than one year; was in several battles and was on the front when armistice was declared. Went into Germany with army of occupation, and about three weeks after firing ceased, suddenly became disturbed and asked to be sent back to the United States. Said German women placed crying babies at his room door so he could not sleep. When babies tired of crying, the German men would place barking and howling dogs at his door for the same purpose. Soon developed headache, speech defects, psycho-motor retardation, and showed typical paretic serology. Was still in the same stupid state when last seen by the writer, about two years after the first symptoms, but had never had another attack of excitement.

Case No. 4.—A white man, doing clerical work. Had chancre at twenty-two. Received treatment for more than two years, according to methods of that day. At forty-six began to lose his efficiency, had memory defects, ideas of grandeur, irregular gait and serological findings were all positive.

Cases similar to the above might be quoted indefinitely, but those are sufficient for the purposes stated.

It will be noted that the time intervening between infection and the appearance of noticeable symptoms of neuro-syphilis was 7, 15, 18 and 24 years, respectively. However, we have cases on record varying in time from less than one year to more than forty years, but undoubtedly the vast majority of cases occur within the limits of from five to twenty years from time of infection.

Since there are so many years between the time of infection and the time when symptoms of neuro-syphilis appear, a great deal

has been written as to what takes place during these years. When does the infection reach the nervous system? Why does it lie inactive so long? Why do some syphilitics develop neuro-syphilis and others do not? And, again, why do some develop the meningovascular type, while others have the parenchymatous type?

Various views have been expressed by different investigators as to all these questions, but as to the time of infection, the most plausible view is that the nervous system is infected at the same time as the rest of the system, that is, along with the appearance of the symptoms of the primary and secondary stages. Such investigations as have been possible are quite suggestive that the spinal fluid becomes positive in some, many years before the appearance of either nervous or mental symptoms.

In order for any pathogenic organism to cause disease, two factors are necessary, namely, an active strain of the organism and a suitable medium upon which this organism may prey. It is a well-known fact that certain organisms may be present in a certain body tissue for many years before it begins to produce symptoms. This is notably true of the tubercle bacillus.

Then it is not unreasonable to believe that in all such cases, including the treponema, either factor above mentioned, or both combined, may be operative. That is, an infecting organism may lie quiescent in a tissue for years solely because the organism is of a weak or benign strain, or the organism may be quite virulent, but lodge in an especially resistive tissue, or an organism of attenuated virulence may lodge in an especially favorable medium and make rather rapid headway, or, again, an organism of decided virulence may reach a tissue especially favorable for its growth. Here one would expect a rapid development and course of disease.

All of these factors may operate in the case of neuro-syphilis and, in addition, there are those who favor the idea that there are certain strains of treponema having a special affinity for nerve tissue. This strain is termed neurotropic. Of all these things we have much to learn, but we already know that nature's laws are exact laws, and when a thing occurs in nature's realm it does not occur as a happen-so, but it is a definite cause followed by a definite effect. Hence, we may expect some valuable discoveries along this line in the not distant future. And in the same connection we are to seek for the real reason why some syphilitics develop neuro-syphilis while others do not, and why some develop one type while others have another type.

When the fields of diagnosis, prognosis and treatment are approached, we again realize that we could use to advantage more information.

A diagnosis of neuro-syphilis should neither be confirmed nor denied on too uncertain findings. Of course, any disease presenting the typical symptoms of a well-worked-out type is easy to diagnose. But neuro-syphilis, like all other diseases, often fails to so announce its presence, while early diagnosis and treatment are exceedingly important for both patient and physician.

As already stated, the spinal fluid has been found positive some years before noticeable nervous or mental symptoms are present. In this connection, Fordyce says: "No case of syphilis should be discharged without the knowledge gained by examination of the spinal fluid." While this is not a bad practice to follow with syphilitic patients who show few or none of the physical signs of neuro-syphilis, and while a diagnosis of some cases of neuro-syphilis may be made from spinal fluid laboratory findings alone, the greatest danger in present-day practice lies in taking a normal spinal fluid to mean that neuro-syphilis is not present. As valuable as the laboratory findings in spinal fluid are, we are to be careful to very cautiously follow out any physical signs present, regardless of normal spinal fluid findings. There are not only cases of neuro-syphilis with normal spinal fluid reactions,

but a few undoubted cases are met with which show both blood and spinal fluid negative. The majority of cases showing a normal fluid are of the meningovascular type of neuro-syphilis, which, by the way, is the type in which present-day methods of treatment hold out the greatest promise. There are, however, cases of parenchymatous syphilis which show a normal spinal fluid.

Those are the cases that give the most trouble, for syphilis is not the only foe lurking beside the pathway of the nervous system, hence the finest points are involved in the differentiation.

This differentiation is not to be gone into here, but too much stress cannot be laid upon the importance of a painstaking neurological examination in every case where the slightest suspicion of a syphilitic pathology is present.

Accepting as true the theory that the nervous system, if infected at all, is infected along with the general systemic infection, the question of the proper treatment of early syphilis takes on a broader aspect. Formerly all have been quite prone to accept of a symptomatic cure and allow the patient to go along under a mantle of false security and later develop neuro-syphilis in its advanced stage, a stage where treatment promises less. So sure is Fordyce that the proper treatment of early syphilis lessens the danger of late neuro-syphilis that he says: "In numerous publications I have presented certain arguments based on observations and study of the general pathology of the disease which have convinced me that practically all types of neuro-syphilis originate within the first year of the infection, and are then amenable to properly applied theropensic."

Then remains the question, what is to be done for the patient who has already developed any type of neuro-syphilis? Not long ago the idea was that when a diagnosis of paresis or tabes was made, nothing more could be done, and that idea is, I think, entirely too prevalent still. Of course, where important nerve structures have been destroyed, they cannot be replaced, but evidence is accumulating daily to show that proper treatment, properly applied, will give great benefit in many cases heretofore considered hopeless. In this connection, no less authority than Solomon says: "The majority of cases of syphilis of the nervous system, whether so-called cerebrospinal syphilis, tabes dorsalis, general paralysis or other forms, are entitled to treatment, and if this is done thoroughly, intensively and systematically, the results will be gratifying. The form of treatment, mercury, iodide, arsenic, intraspinous and intracranial injections and the amounts, will necessarily depend upon the condition in each individual case."

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## TWO ANOMALIES OF PREGNANCY.*

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Case No. 1.—*Abdominal Pregnancy.*—Negro woman; age 36. Mother of six children. Consulted a physician because of rapid enlargement of abdomen of less than five months' duration. Cessation of menstrual period for five months previous to operation. Patient referred to me for operation, with a diagnosis of ovarian cyst of right ovary. There had been no pain at any time. No loss of weight. No inconvenience. Nothing to attract the patient's attention to her condition other than rapid increase in right side of abdomen.

*Operation.*—Abdomen was opened with a median line incision. After opening the peritoneum, I noticed a similar looking membrane adhering to peritoneum on right side, containing fluid, which later proved to be amniotic fluid, and a well-developed male fetus, indicating about a five and one-half months' pregnancy. The amniotic membrane was attached to the peritoneum in

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front; no other attachment discernible. Just posterior to this membrane was the placentae, as large as to be found at end of full-term pregnancy. The placentae was adhered and continuous with the omentum, enough so that it was impossible to tell where the one began and the other ended, and from the omentum came most of its bloody supply. The placentae was also adhered to the lateral wall of the abdomen, ascending colon, caecum and vermiform appendix, all of which contributed some blood supply. The appendix was not only adhered to, but buried in the placental mass. The right tube was a typical pus tube. No evidence of a rupture or that it had ever contained the ovum during its developmental stage. The right ovary was cystic, but in no way attached to the placentae or membrane containing the fetus. The uterus was not enlarged. There were no changes in the left tube and ovary.

Berkeley and Bonnie[1] classify abnormal situations in pregnancy as follows:

1. The cervix (this is questionable); 2, the lower uterine segment (placentae praevia); 3, the junction of the upper and lower uterine segments; 4, the upper segments; 5, the fundus; 6, the cornua; 7, the interstitial portion of the tube; 8, the isthmic portion of the tube; 9, the ampullary portion of the tube; 10, the fimbriated extremity; 11, the Graafian follicle, and 12, the peritoneum. This last is not proven.

Williams,[2] in his classification, states: "As the fertilized ovum may be arrested at any point on its way from the Graafian follicle to the uterine cavity, it may undergo development in the ovary or in any portion of the tube, giving rise to ovarian or tubal pregnancy, respectively. It is doubtful whether the ovum can become implanted upon the peritoneum and a primary abdominal pregnancy follow."

I am fully cognizant of the fact that at present most authors admit the theoretical possibility of abdominal pregnancy, but are extremely skeptical as to its actual occurrence.

If the case just reported was not one of abdominal pregnancy primarily, then what was it? Whether pregnancy first took place in a small accessory tubal ostium that later on became obliterated, and leaving no evidence, I am unable to say.

Case No. 2 I am masquerading under the title that really belongs to Case No. 1, but inasmuch as it is the end result of pregnancy, I shall report it.

Case No. 2.—*Anomaly of the Fetus.*—Mrs. J. R. B.; age 22. Neurotic; primiparae; entered hospital for confinement. Family history, negative. Past history, negative. Labor was normal and child was delivered without forceps. The head and extremities of fetus were well formed. There was an entire absence of sternum and anterior abdominal wall. The heart was anterior to the anterior chest wall and was absolutely bare. No pericardium or any other covering over heart muscle. The lungs were normal and enclosed in the thoracic cavity. The ribs on the left side going behind the heart and attached to the muscles in front of the spinal column, being continuous with the attachment of the ribs on the right side. The liver, stomach, large and small intestines, omentum, pancreas, spleen and urinary bladder were all bare. The abdominal parietes only incased the kidneys.

I merely report these two cases because of their rare occurrence and failure on my part to find identical abnormalities reported in literature that I have reviewed.

[1] Berkeley & Bonney, Textbook, p. 530.
[2] Williams, 4th Edition, Text Obstetrics, p. 677.

## INDIGESTION IN THE YOUNG INFANT.*

J. H. Fellows, M. D.,
Pensacola, Fla.

Indigestion in the young infant is a condition due usually to improper feeding, overfeeding or too frequent feeding, and not, as is often the case with the adult, due to an

*Read before the forty-eighth annual meeting of the Florida Medical Association, at Pensacola, May 10, 11, 1921.

organic disease or a deficiency of one or more of the digestive juices, and therefore cannot be relieved by drugs.

This condition is naturally divided into two classes: First, that occurring in infants fed on the breast, and second, that occurring in infants fed from the bottle. But it is beyond the scope of this short paper to deal with but little of the phases of the second class, as that would necessarily include artificial feeding and its various perplexities and uncertainties.

By far the most frequent cause of abdominal pain in the first few months of life is due to indigestion and fermentation. Many of us, I am sure, have seen convulsions in older children that we could account for in no other way than from irritation caused by undigested particles of food in the intestinal tract.

Indigestion in the young infant is quite common indeed, so common is it that the old granny has called it the three months' colic. And it has often been passed up in the hope that it would disappear in three, or four, or five months.

I know of nothing that disturbs the young mother quite so much as the prolonged screaming of her baby, or nothing that seems to give the infant more pain than what is ordinarily termed colic.

The symptoms appear pretty soon after feeding. At first the patient begins to twist and squirm, and plainly shows it is uncomfortable. It throws the head back and draws the limbs up in an effort to give the distended abdomen more space. This in time is followed by crying and screaming which no amount of soothing will relieve.

If this condition is allowed to continue the stools will become loose and there will develop a tenesmus and straining, a combination that must tend to upset the nervous stability of these little ones, which undoubtedly influences the nervous system of later infancy and childhood.

In this connection I wish to report a case which came to me about three months ago. This patient, L. B., at the age of two months was brought from a nearby town, with the history of having five or six loose stools daily, accompanied by straining and tenesmus, and that the baby was able to sleep but very little because of the pain, screaming and general discomfort. The mother thought something was wrong with baby's neck, as it would throw its head back during the attacks.

On examination, the abdomen was found to be markedly distended with gas, and patient was fretful and plainly showed it was uncomfortable. It had been given Bulgaria tablets and the various caminative mixtures. Its feeding intervals had been changed from two to three and three to four hours, all of which failed to give more than temporary relief. I examined the breast milk and found it normal, so advised this mother to weigh this baby before and after nursing for twenty-four hours. Six a. m., it received three and one-half ounces; 10 a. m., four ounces; 2 p. m., three ounces; 6 p. m., two and one-half ounces. After nursing twenty minutes, plainly showing that it was being overfed, I advised nursing ten minutes and making nurse slowly, *e. g.*, nursing one minute and crying one minute. The results were most miraculous. In two days the stools were less frequent and patient did not throw his head back, and seemed perfectly comfortable.

I think it is quite well agreed among men who have had experience in using long intervals in feeding young infants, that it has a decided advantage over the old method of two and two and a half hours. But it will not solve all cases as with the one just reported.

Case No. 2.—Claude A., I saw when two weeks old with the complaint: Breast does not agree, reguritates food and has from six to twenty loose, green stools daily. The nursing intervals on this patient were from fifteen minutes to two hours. Weighing the baby before and after nursing revealed the fact that it was getting from three to four

ounces at a feed. It had gained a pound since birth, *c. g.*, in two weeks, yet the mother thought the breast was not agreeing with the baby. This infant was placed on three-hour intervals and made to nurse slowly, which entirely cleared up his condition in four days.

CASE No. 3.—C. H., I saw April 7, 1921; age, five weeks. (He has a common story.) He was nursed until ten days old, during which time the mother reported he spit food, was constipated, fussy, fretful and cried a great deal. The mother was advised by her physician to wean the baby and give it a formula of malted milk, which it received until I saw it. Up to this time it had lost two pounds, or 25 per cent of its weight, and was having four or five loose stools daily, which latter was the complaint for which the baby was brought. I found the mother still had a slight secretion of milk, so advised putting the infant back on the breast and supplementing with a formula of modified cow's milk after each nursing. The first week the baby gained eight ounces, and it has since continued to gain and do well.

I do not believe that indigestion in the young infant is ever a cause for weaning. If we feel that the baby must have more food or other food, prescribe it, but do not take it from the breast, for there is no formula which can do more than approach the ideal.

So the relief of this condition lies in the recognition of its cause. In fact, I may say most cases will be relieved by changing the nursing intervals. In other cases the mother is not taking sufficient out-of-door exercise, or the milk may be too rich in fat or the reverse, or the baby's feet are allowed to remain cold. But patience on the part of the mother and patience on the part of the doctor will usually solve the problem. In the second class, or bottled-fed infants, the cause usually lies in the feeding formula, which must necessarily be fitted to the needs and digestive capacity of the patient. The problems here presented are usually quite different because the baby is fed a foreign or artificial food. In many instances, the physician will tell the inexperienced mother to feed the infant a little malted milk or put the baby on condensed milk or cow's milk, etc. If he would take a little more time and be more specific in his directions, the baby and mother would be guarded against much trouble and discomfort. If the infant is started on a formula that is too strong, or is given more than it can take care of, its digestion will be upset. Some mothers have no conception of the amount the young infant should take at a feed. I have seen an infant a few weeks old offered eight ounces. These are usually the infants that give so much trouble and come with a history: "We have tried everything and nothing agrees with the baby." These add largely to our class of difficult feeding cases, and also to the death rate in bottle-fed infants. Thus it surely behooves us to be more careful and explicit in prescribing the first formula for the young infant or in removing it from the breast, for on this, to a great extent, the future health of the child will depend.

## PROPAGANDA FOR REFORM.

ANOTHER REMONSTRANCE AGAINST MERCURY INHALATION.—During the last few years the attention of the medical profession has been directed by clever propagandists to the treatment of syphilis by procedures which involve the volatilization of mercury-containing mixtures by heat and the inhalation of the resulting volatile products. There is nothing novel in the principles concerned. Inhalations as well as fumigations of mercury have been tested at various times and the procedures have been abandoned because of the uncertain dosage. The Council on Pharmacy and Chemistry has refused to endorse preparations proposed for the treatment of syphilis which depended essentially on the administration of mercury by inhalation (Spirocide not admitted to N. N. R.). In this decision, it is sustained by a reinvestigation of the inhalation treatment of syphilis carried out by Cole, Gericke and

Sollmann. The investigators point out that the assumption that mercury is more promptly absorbed by the lungs was based on physical misconceptions. In fact, the mercury is condensed on the mucous membranes of the mouth, pharynx and respiratory tract. That in the mouth and pharynx is, for the most part, swallowed, and the absorption then takes place by the gradual conversion of the mercury into soluble compounds. In other words, the administration of mercury compounds by inhalation has no advantage over oral administration. It has the serious disadvantage of indefinite dosage. (*Jour. A. M. A.*, March 4, 1922, p. 654.)

Collosols (British Colloids, Ltd.).—Collosols is the trade name applied to certain alleged colloidal preparations of drugs made in the Crookes Laboratories by British Colloids, Ltd., London. The Collosols are recommended for external, internal, intramuscular and intravenous administration. A few years ago the Council on Pharmacy and Chemistry investigated the Collosol products and found that some of the specimens contained precipitates, and thus they were not colloidal. Commenting on the presence of precipitates, the Council pointed out that if "injected intravenously as directed, death might result, making the physician morally, if not legally, liable." In the cases in which the therapeutic claims for Collosols were examined, the claims were found to be either exceedingly improbable or exaggerated. In the Collosol "literature" there are frequent references to enthusiastic reports by Sir Malcolm Morris, K. C. V. O., F. R. C. S. E. This medical knight seems to have devoted his energies to the exploitation of Collosols and is reported to be one of the directors of the Collosol concern. (*Jour. A. M. A.*, March 4, 1922, p. 674.)

The Demand for Vitamins.—Ordinary fresh foods are the simplest, cheapest and richest sources of vitamins, yet vitamin "concentrates" are being "demanded" by the public because shrewd, forward-looking "patent medicine" exploiters are using all the subtle art of modern advertising to convince the public that it is in serious danger of vitamin starvation, and that the only hope lies in buying these alleged concentrates to make up a hypothetic deficiency. Advertising campaigns, such as these of the vitamins, constitute a vicious circle; an artificial demand is created, and then the manufacturer excuses his business on the ground that he is merely supplying a demand. (*Jour. A. M. A.*, March 18, 1922, p. 810.)

More Misbranded Nostrums.—The following preparations have been the subject of prosecution by the federal authorities charged with the enforcement of the food and drugs act: Krause's Phosphorets (Norman Lichty Mfg. Co.), consisting essentially of ferrous carbonate, asafetida and traces of phosphorus, and claimed to cure diseases resulting from a shattered nervous system. Binz's Bronchi-Lyptus (Edward G. Binz), consisting essentially of a solution containing oils of eucalyptus and peppermint, glycerin, sugar, acacia, alcohol and water, and claimed to be an efficient remedy for croup, whooping cough, sore throat, etc. Dr. Goodwin's Herbal Compound (Dr. F. A. Goodwin), a mixture of plant material containing chiefly senna, fennel, uva-ursi and unidentified plant extractives, and sold for diseases of the stomach, liver, kidneys, nerves, bowels, bladder, etc. Dubois' Pecific Pills (W. J. Baumgartner), consisting essentially of aloes, ferrous sulphate, calcium carbonate and sugar, claimed to be a reliable female tonic, etc. 4-11-44 Capsules and Injection (A. J. Benson), the capsules containing cubebs and copaiba, and the liquid, a solution of zinc sulphate and salt, sold for the treatment of gonorrhea, etc. Metzger's Catarrh Remedy and Spede Oil (Metger Mfg. Co.), the first consisting essentially of iodid and mercuric compound, gentian, alcohol and water, and the second consisting essentially of gasoline, oil and eucalyptus, methyl salicylate, menthol, camphor and ether. (*Jour. A. M. A.*, March 4, 1922, p. 672.)

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## THE HAVANA MEETING.

Arrangements for the forty-ninth annual meeting of The Florida Medical Association which is to be held in Havana, Cuba, are being rapidly completed. The actual date of the meeting has been set for June 27th and 28th. The party leaving Jacksonville will travel by way of the Florida East Coast Railway, leaving the Terminal Depot at 3 p. m. on Sunday, June 25th. Arriving in Key West at 9:10 the following morning, connections will be made with the Peninsular and Occidental Steamship Company's magnificent S. S. Cuba which will sail at 10 a. m., arriving in Havana at 5 p. m. the same day (Monday, June 26th).

The Tampa party will sail on the S. S. Cuba on Sunday afternoon, June 25th, from Port Tampa, at 2 p. m., arriving in Key West the following morning at 7 o'clock, the entire party sailing for Havana at 10 o'clock.

The Florida East Coast Railway has granted to the Association an excursion rate from Jacksonville to Havana and return of fifty dollars and forty-five cents ($50.45), with a proportionate rate from all stations on the line south of Jacksonville.

The Peninsular and Occidental Steamship Company has granted for the benefit of Association members living in the Tampa territory, an excursion rate of thirty-five dollars and fifty cents ($35.50) from Port Tampa to Havana and return by way of Key West. To this must be added three dollars for revenue stamps.

Association hotel headquarters will be at the Hotel Sevilla, where a special rate has been extended to members of the Association, their families and guests. The following room rates will prevail: Rooms facing the court (two in a room), $6.00 per day; rooms on the outside (two in a room), $8.00 per day. All rooms having baths.

The officers of the Association have made no attempt to arrange a return schedule, as it is anticipated a large number of those in

attendance will make side trips after the Association adjourns on the 28th. As a matter of general information, however, steamers sail from Havana for Key West daily at 10:30 a. m., excepting Sundays, and for Tampa on Tuesdays and Saturdays at the same hour.

It is requested that all members in the Jacksonville territory anticipating making the trip notify, as early as possible, Dr. Graham E. Henson, Secretary, Florida Medical Association, Consolidated Building, Jacksonville, stating the number that will be in their party and the Pullman space desired.

Members living in the Tampa territory going by way of Port Tampa, should make their reservations through Mr. R. D. Stephens, ticket agent, the Peninsular and Occidental Steamship Company, Port Tampa, Florida.

The Secretary of The Florida Medical Association has recently received a communication from the Secretary of The Georgia Medical Association stating that a number of Georgia physicians had expressed a desire to make the trip to Havana, and asking whether they would be welcome and as to whether they would be given the benefit of excursion and hotel rates. This has been secured for them and the Secretary of The Georgia Medical Association assured that all would be welcome.

A large time is anticipated by all. "Ain't it a grand and glorious feeling?"

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## JACKSONVILLE CLINIC.

The Duval County Medical Society is arranging for a clinic week to be held in the hospitals of Jacksonville, beginning Wednesday, and concluding at noon Saturday, June 7th to 10th, to which the doctors of Florida and South Georgia are invited. Programs are expected to be ready about May 15th. The arrangements are in charge of Drs. A. H. Freeman, Clayton Washburn, and C. J. Lewis.

## THE ST. LOUIS MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The arrangements of the St. Louis profession for the meeting places for the session of the A. M. A., which is to be held in their city May 22nd to 26th, next, are singularly fortunate and convenient. Never has the Association been so well favored in this respect. The district in which the meeting is to take place is at the west edge of the business section of the city, easily accessible from all directions by street car or otherwise, and not more than fifteen minutes' street car ride from the most distant hotel. The grouping of the meeting places is so compact that should one walk from the Registration Building (Moolah Temple) to the farthest hall, it can be done in ten minutes or less. From section to section is a matter of from one to five minutes. The convenience of the location and arrangements of the different halls is more outstanding than in any other city in which the Association has met, and a decided improvement over the accommodations which were had at the meeting in St. Louis in 1910.

The registration office, postoffice and commercial exhibit is to be in the Moolah Temple (Shrine), a beautiful and commodious building on Lindell boulevard, two blocks west of Grand avenue. At the other extremity of the group is the Odean, the home of the St. Louis Symphony Orchestra, with a main hall which seats better than 2,000, and several lesser halls. The main hall will be used for the opening session. Its acoustics are particularly good and suited to our purpose. The Sections on Practice of Medicine and of Diseases of Children meet here. In the assembly hall of the same building the Sections on Pharmacology and Therapeutics, and on Pathology and Physiology will meet. (It will be noted that there has been an aim to foregather closely allied sections.) The Sheldon Memorial, a very beautiful,

new hall on Washington avenue one-half block west of Grand avenue, which most admirably meets all requirements, will be the meeting place of the Sections on Ophthalmology, and Laryngology, Otology and Rhinology. The Section on Surgery, General and Abdominal, and on Obstetrics, Gynecology and Abdominal Surgery, will be held in the Third Baptist Church on Grand avenue, a situation well suited to the demands. The Sections on Orthopedics and Nervous and Mental Diseases will meet in the Law School of the St. Louis University on Lindell avenue, a few steps west of Grand avenue. The hall easily seats 500 and is both comfortable and convenient. Dermatology and Syphilis and Urology will use the large Union Methodist Church on Delmar avenue just west of Grand avenue, which meets every requirement. The Sections on Gastro-Enterology, Proctology and on Preventive Medicine will use the large hall in the Musicians' Club on Pine street east of Grand avenue, and next to the building of the St. Louis Medical Society, where the House of Delegates will hold its sessions. The Section on Stomatology is assigned to the assembly hall of St. Peter's parish house, one block west of Grand avenue on Lindell. Immediately in this district will be found three of St. Louis' most important clubs, the St. Louis, University and the Columbian. Restaurants catering to every grade of patronage are numerous in the district, and precautions have been taken to insure that normal rates continue during the meeting.

The St. Louis profession is preparing for an unusual attendance. Hotel reservations are coming in rapidly, but it is purposed that even the late-comer shall be comfortably housed. The wise traveler, however, makes his reservation as early as he finds it possible. Dr. M. B. Clopton, 3525 Pine street, St. Louis, is Chairman of the Committee on Sections and Section Work.

## THINGS WE OUGHT TO KNOW.

That many eminent physicians and surgeons have been sons of clergymen. Robert James Graves was one of these. Graves was the son of a Dublin clergyman (1796-1853) and was graduated in medicine in 1818, about the time Chicago was a village. In 1835, Graves published in *The London Medical and Surgical Journal* a description of exophthalmic goiter so admirable in outline that the disease goes by his name to this day. He requested that the phrase, "He fed fevers," should be his epitaph. He also wrote early accounts of angioneurotic edema and scleroderma. He inaugurated timing the pulse by the watch and discarded the old lowering or antiphlogistic treatment of fevers. Graves was tall, dark and somewhat sarcastic of speech, but really had a warm heart. His methods made a profound impression upon his Irish colleagues of his time.

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We should know that William Stokes (1804-78) was Graves' colleague. In 1825, Stokes came on record by his publication of his "Introduction to Use of Stethoscope," and in seven years published his first account of Stokes-Adams' disease. His treatises on diseases of the chest and diseases of the heart and aorta won him lasting fame.

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The prominent English clinicians of the days of Graves and Stokes were John Bright, Sir Dominic John Corrigan, Thomas Addison, James Parkinson, Thomas and Joseph Hodgson. It was not until the beginning of the nineteenth century that there was any real organization in medical progress. It was not until a long time after the Revolutionary war that there was any medical literature published in America. The first medical book published in America was published in Mexico City, in Spanish. Benjamin Franklin published some medical literature on his own press in Philadelphia at an early date and described the use of a flexible catheter.

It is well to know that Thomas Hodgkin (1798-1866), of Tottenham, England, was a Quaker and always wore their distinctive dress. Hodgkin was a reformer by nature and, it is said, was driven out of Guys Hospital by his independence. He was distinctly independent and almost eccentric. The eccentricities of those great men early in the last century may have caused many rudimentary physicians to assume wisdom and wish to appear learned and wise, as was conspicuous fifty years ago amongst medical men. Hodgkin's reputation was made from his original work and observation upon simultaneous enlargement of the spleen and lymphatic glands which Wilks later called "Hodgkin's disease." He wrote an account of aortic insufficiency in 1829 which antedated Corrigan's classical contributions.

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Richard Bright (1789-1853), of Bristol, England, was the leading consultant in London at that time. Bright was connected with Guy's Hospital for over twenty-three years and at other times did considerable traveling in Europe. It is said that he illustrated some of his own works by drawings he had made during his travels. He was simple and unprejudiced, seeking the truth. As a botanist and geologist, he ranked high. His reputation in medicine was established in making a distinction between cardiac and renal dropsy. This work was of immense importance to medical practice. It was in observation that he excelled, and it is recorded that he could not theorize. His pathological work on the kidneys was the greatest of his time. His accounts of pancreatic diabetes and acute yellow atrophy of the liver were the authority in that day. In his work he described certain convulsions of Jacksonian epilepsy and "status lymphaticus." He gave accurate accounts and plates of the pathology of nephritis, cerebral disease and acute yellow atrophy of the liver. He appreciated the worth of Addison, his colleague.

Thomas Addison (1793-1860), of Longbenton, Cumberland, was associated with the celebrated Bright at Guy's Hospital in London. Conjointly with Bright, he wrote a practice in which he was frankly agnostic regarding obscure phenomena. Addison was never the successful practitioner that Bright was, however. He was more of a writer, lecturer and teacher, at home with his pupils in hospital work. He was shy, sensitive, and brilliant. His haughty manner concealed his shyness. As a pathologist and diagnostician, he excelled. Addison attached little importance to drugs and drugging (which was perhaps excessive at that time), though "Addison's pill" of calomel, digitalis and squills, for hepatic dropsy in syphilis, is still used. In 1849 he described pernicious anemia and disease of the suprarenal capsule ("melasma suprarenale"). This work really inaugurated the study of the ductless glands. He wrote the first book in English on the action of poisons in the living body (1829). It was Trousseau who proposed to call the suprarenal syndrome "Addison's disease."

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We ought to appreciate more the contributions to medicine made by that wonderfully versatile American, Benjamin Franklin (1706-1790). We had little or no literature in American medicine in his day. There have been few men of his equal in any age. This remarkable man invented bifocal lenses (1785) and a flexible catheter and contributed to the treatment of nervous diseases by electricity. He wrote on deafness, gout, sleep, lead-poisoning, heat of the blood, infection from dead bodies, death rate in infants and medical education. Quite a legacy for even a medical man! He wrote, by request, a history of the Pennsylvania Hospital of Philadelphia, of which he was the principal founder (1751). This history was printed on his own press. He wrote a pamphlet on inoculation in smallpox, and his "Dialogue With the Gout" has been republished many times.

# PUBLISHER'S NOTES

## A NEW LOCAL ANESTHETIC.

From time to time new anesthetics to take the place of cocaine have been proposed and, to some extent, used, but without utterly supplanting the older and rather dangerous drug. Now, however, the surgeon has a substitute that is a decided improvement. The new local anesthetic is called Butyn (pronounced *Bute-in*, with the accent on the first syllable). It is the discovery of Professors Roger Adams and Oliver Kamm, of the University of Illinois, and Dr. E. H. Volwiler, of The Abbott Laboratories, Chicago.

The anesthetic has been passed by the Council on Pharmacy and Chemistry of the American Medical Association. In his report, Dr. E. E. Bulson, Jr., for the Committee on Local Anesthesia, Section of Ophthalmology, said that it acts more rapidly than cocaine and its action is more prolonged. Less is required, and in the quantity necessary it is less toxic than cocaine. It has other advantages which make it highly useful, especially for eye work. A solution can be boiled without impairing its efficiency.

The Abbott Laboratories is supplying Butyn, in tablets (with and without Epinephrin) and 2% solutions, which may be had without narcotic blanks.

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## IODALBIN.

The iodides have held their ground in professional esteem, not because but in spite of the attitude of the patient toward them. They are disagreeable to take, and yet, in many cases, prolonged courses of treatment are necessary. An iodine compound that does not dissolve in the stomach, and is therefore without irritating effect upon that organ, is marketed by Parke, Davis & Co. under the name Iodalbin—an albuminate or protein compound of iodine.

Iodalbin contains about 22 per cent of iodine in organic combination—not a large proportion as compared with the iodides, and yet the dose is about the same, for the reason, as stated by the manufacturers, that the iodine in Iodalbin remains in the tissues, accomplishing its therapeutic mission, much longer than the iodine in inorganic combinations.

Iodalbin is put up as a powder in ounce vials and in 5-grain capsules.

**Calcreose**

**In Bronchitis and Tuberculosis**

**Calcreose** is particularly suitable as an adjunct to other remedial measures. **Calcreose** contains 50% creosote in combination with calcium. **Calcreose** has all the pharmacologic activity of creosote but is free from untoward effects even when taken in large doses for long periods of time.

**Sample** 4 grain tablets supplied to physicians upon request.

**THE MALTBIE CHEMICAL CO., NEWARK, N. J.**